Arizona State Veteran Home - Phoenix
4141 N. Third Street
Phoenix, Arizona 85012

Functional Assessment

Applicant's Name:_____ Date:_____

Date of Birth:_____ Current Living Arrangements:_____

_____

Person Completing this Form:_____ Relationship to Applicant_____

Applicant's Medical Diagnoses:_____

_____

For each area of functioning listed below, please describe to the best of your ability the amount and type of assistance the applicant requires.

BATHING

Does applicant take shower, tub bath or sponge bath_____

How often does he/she bathe_____

How much assistance is needed?_____

DRESSING

How much assistance does applicant receive in dressing (including selecting and getting clothes from closet, putting on undergarments and using fasteners)?_____

_____

_____

Additional Comments_____

_____

Toileting

Does applicant require assistance with toileting (including getting to and from bathroom, cleaning self after elimination and arranging clothes)?_____

If yes, how much assistance is needed_____

_____

Does applicant have a catheter? What type?_____

Does he/she have a colostomy?_____

Is applicant able to control urination?_____ Bowel Movements?_____

If no, how often do "accidents" occur?_____

Mobility

Does applicant walk (list assistive devices used i.e., walker, cane) or does he/she use a wheelchair?_____

Does he/she need assistance getting out of bed or chair?_____

If yes, how much assistance is needed?_____

_____

Eating

Does applicant feed self or require assistance eating?_____

_____

Does he/she use adaptive equipment while eating (i.e., plate guard, special spoon, etc.)?

_____

Is he/she on a special diet?_____

How would you describe applicant's appetite?_____

Height_____ Weight_____

Medication

List applicant's current medications:_____

_____

_____

Any known drug allergies?_____

_____

Is applicant using oxygen (if yes, how much and how often)?_____

_____

Protheses

Does applicant have an arm or leg prothesis?_____

Does he/she wear dentures (upper and lower)?_____

Does he/she use hearing aide?_____

Can applicant apply own prothesis?_____

Skin

Does applicant presently have bed sores (if yes, where and for how long)?_____

_____

Does he/she have skin rashes?_____

Does he/she experience swelling of the legs or feet?_____

_____

Orientation

Is applicant alert and oriented or does he/she exhibit confusion? (If confused, is it ongoing, often, or occasional?)_____

_____

For individuals who are confused and disoriented:

Does the applicant attempt to wander?_____

If yes, how often?_____

Is he or she willing to return if given direction?_____

Other Health Considerations

Does applicant currently use physical or chemical restraints? If yes, describe type and frequency:_____

_____

Has he/she ever been hospitalized for mental health problems? If yes, state when, where, and why:_____

_____

Does applicant maintain active and satisfying relationships with family and friends?____

_____

Does he/she have history of drug or alcohol abuse? If yes, please describe:_____

_____

_____

Is applicant currently receiving physical, occupational, speech, or respiratory therapy? If yes, list type of therapy, reason for, and frequency received:_____

_____

_____

Additional Comments:_____

_____

_____

_____